atomy, while since that preliminary epoch the subject of spinal sensory representation has been exhaustively examined by Sherrington and by Head, with the result that the topographical areas of the different spinal roots are now well defined. The conclusion reached is that it is perfectly clear that what may properly be termed the mid-axial line and region of the hand and forearm is as definitely represented in the cerebral pallium as it distinctly is in the spinal cord. It is perhaps natural to expect that this should be so, because any contrast between the post-axial and pre-axial portions of the limbs respectively, presupposes an imaginary frontier line between them, and further, the cerebral memorialisation of the transfer of the limb to and from the mesial plane of the body demands that the cerebral pallium should have particularly localized within it the orientation of the middle point of the limb which is thus translated from or to the sagittal mesial plane. This further proof of similarity between the sensory representation in the spinal cord and cerebral pallium is confirmatory of the other phenomena described.

Jelliffe

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1. The Symptomatology of Hemiplegia. HEILBRONNER.
2. The Status Hemiepilepticus Idiopathicus; Eight Clinical and Anatomical Observations. MÜLLER.
3. A New Algesimeter, with a Critical Description of the Previous Algesimetric Methods. THUNBERG.
4. Tumor of the Hypothesis Without Akromegaly. KOLLARITS.

1. *Hemiplegia.*—Upon the cadaver it may be observed that the outer contour of the thighs is more convex than during life. The same appearance may also be observed in the affected leg in cases of recent hemiplegia. A somewhat similar appearance may be observed in the calf and arm muscles. Heilbronner calls this condition "the broad leg." It is not present in sleep, nor in unconsciousness, nor in profound narcosis. It is present in severe acute polyneuritis, but was not found in tabes, in chorea, in Huntingdon's disease, or in hysterical flaccid hemiplegia. It is not certain that it will serve in the differential diagnosis of cerebral and spinal hypotonia. The broad leg is not dependent upon the disappearance of the patellar reflex, or even upon the return of voluntary movement; but if it persists the contractibility of the quadriceps to percussion upon its tendon is usually lost. After some discussion of the reflexes and muscle tone Heilbronner reaches the conclusion that in the course of recovery from hemiplegia the following series of events occurs. First, return of active motion; second, return of the contour-preserving tone; third, the return of the reflex muscle tone. With reference to certain other clinical phenomena he states his belief that the superior restoration of the function of the leg is merely apparent. He also discusses the hemiplegic gait, and calls attention to the importance of educating hemiplegics how to walk properly. He describes a curious form of rhythmical movements of the arm during walking, which are entirely involuntary. They consist of a flexion and lifting of the forearm, and may occur when apparently all the symptoms of hemiplegia have disappeared.

2. *Status Hemiepilepticus.*—Although it is generally supposed that partial or Jacksonian epilepsy is due to some focal lesion in the brain, a number of observations have been recorded in which such partial epilepsy has existed although examination of the brain has been entirely negative. Müller collects from the service of Nonne eight cases of partial epilepsy. The first, an alcoholic and leutic man of 26, who had had an injury to the head. There was left-sided status epilepticus not relieved by trephining. The macroscopical examination of the brain was negative; apparently a microscopical examination was not undertaken. The second case, a

chronic alcoholic, died in left-sided status epilepticus. At that autopsy there were various lesions of the body, but the brain was microscopically normal. The third case, a chronic epileptic, 38 years of age, had 306 attacks, involving only the left side of the body. At the autopsy an area of softening was found on the basilar surface of the right frontal lobe. Elsewhere the brain appeared to be normal. The fourth case, a boy of 19, had symptoms of acute meningitis, then left-sided epileptic attacks and death. There was a diffuse chronic meningitis in the base of the brain, but no alteration in the substance of the brain. The fifth case, a woman of 37, had epileptic attacks limited to the left side; there was a history of injury to the brain. There was high fever, cyanosis, and loss of pupillary reaction. The ophthalmic examination indicated disturbance of the optic nerves. At the autopsy nothing abnormal was found, either in the brain or body, and a microscopical examination of the former organ was negative also. The sixth case, a girl of 18, had albuminuria, and right-sided epileptic attacks. The brain was normal; the kidneys only slightly affected. There was hypoplasia of the aorta. The seventh case, a man of 37, in the course of diabetes mellitus developed typical Jacksonian epilepsy. At the autopsy the brain was normal, but there were changes in some of the abdominal organs. The eighth case, a boy of 6, had general epileptic attacks at the age of 4 years. Two years later he suffered from epileptic attacks, limited at first to the right side, then to the left side of the body, profound coma, gnashing of the teeth and trismus. Later he developed measles, and made a complete recovery. It seems wisest, in the absence of more definite knowledge, to regard these cases as atypical forms of general epilepsy.

3. *Algesimeter.*—Thunberg describes this algesimeter, which consists essentially of a lever, to one end of which a needle is attached, and to the other end a weighted screw, by which it can be brought into a state of equilibrium. The arm to which the needle is attached is divided into ten parts. The instrument is brought into a state of equilibrium and then weights hung upon the arm. The position and size of the weight determines the amount of pressure exerted. This pressure is increased until the patient experiences pain. The paper is concluded with a valuable critical description of the various instruments hitherto divised for the purpose of measuring sensation.

4. *Hypophysis Cerebri Without Akromegaly.*—Kollarits tabulates a series of cases in which there was tumor of the hypophysis cerebri, without akromegaly. Among these he includes two cases of his own. Usually these tumors occur in young persons, but Kollarits is of the opinion that a careful consideration of the cases suggests that tumor of the hypophysis is merely one of the symptoms, and not the cause of akromegaly.

J. Sailer (Philadelphia).

Miscellany

TABES DORSALIS AND PSYCHOSIS. M. Bornstein (Monatsschrift für Psychiatrie and Neurologie. Vol. 17, 1905).

Many authors claim that the psychical manifestations of tabes are purely of a paretic nature. Bornstein discussed the many difficulties one experiences in making a differential diagnosis between general paralysis and other mental disorders. The author makes abundant reference to the literature of tabes and psychosis, and among others he quotes the following important neurologists and psychiatrists. Cassirer differentiates between the elementary psychopathic symptoms of tabes from a fully developed psychopathic state. The tabetics as a rule manifest extraordinary quietness, even striking cheerfulness, which they exhibit in spite of the pain they endure. Other authors are more reticent in generalizing their observations. Leyden and Goldscheider assert that the emotional tone in the tabetic is variable, as characteristic of all chronic diseases. Cassirer